

The delegation of surgical responsibility

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Editor's note

Delegation of specific tasks during surgical operations to medical, nursing, technical or other assistants does not detract from the supervising surgeon's overall moral responsibility for his patient, but delegation of independent responsibility to propose and complete curative operations to non-surgeons or less than fully trained surgeons cannot be ethically justified in a prosperous society. In a society too poor to provide reasonably full surgical cover, this principle may have to be modified. It is suggested that the provision of surgical care in such circumstances by doctors without full surgical training might be ethically acceptable, though not surgery by the medically unqualified.

The fundamental contract in surgery is an undertaking by one individual to cure another by operation, in the expectation of reward. It implies firstly that the patient will be the better for the treatment. Secondly, it implies that this treatment will be planned in the patient's best interests, and that these remain the paramount consideration. The surgeon should do everything in his power to achieve the result he has suggested. His responsibility to the individual patient is total and continued until he judges he has secured the proposed results.

It has come to be assumed that no one should be allowed to make such a contract, that is to practise surgery, until 'the best in his power' has reached a certain level. As it was expressed in the Charter of the Royal College of Surgeons of Edinburgh in the year 1505, 'No man shall occupy the craft of surgery except he be worthy and expert and diligently examined'. This is the essence of a profession as distinct from a trade.

Secondly it is assumed that 'only the best is good enough'. The surgeon has a duty to continue to enlarge his skills, to keep himself abreast of progress, and to insist on the best materials and circumstances for his patient. In other words, surgery is a growth industry.

Dr Nilsson has discussed some of the factors which make it difficult for the individual to fulfil this contract. Central to it is the definitive operation and common to Dr Nilsson's paper and mine are the questions of the extent to which a surgeon may

delegate this act to another, and to which surgeons, in the plural, may delegate surgery to others.

To start with the particular case, we must acknowledge that the contract is interpreted with various degrees of freedom according to the status of the surgeon, be he a private practitioner making direct arrangements with the individual patient, senior surgeon of a teaching hospital with a commitment to let others gain experience, or whole-time member of a state health service. The need to delegate is most often associated with training or with shedding of a consultative load too heavy for one man to translate into operation.

In either of these circumstances it seems generally accepted that one can only delegate operation with the informed consent of the patient. I understand that is the legal position in the United States. In British hospitals the form of consent to operation may state that the patient recognises that operation may not be carried out by a particular surgeon. Certainly it is quite common to find patients who neither know nor seem to care who has committed major surgery upon them. Clearly we have moved some way from what we recognise as an ideal base, but there is no question so far of delegation to a subordinate - sub-professional - cadre.

I do not want to deal with the complexities of a surgeon's responsibilities in law for the acts of his associates. Sticking close to the operation itself, we may suppose that, when this has been delegated to another, with the patient's consent, the responsibility rests with the deputy. Furthermore, whoever does the operation assumes at least a moral responsibility for the conduct of ancillary procedures - eg passage of catheters, intravenous infusions - by his assistants. He has the responsibility at least to see that these acts are carried out precisely as he wishes. It is in relation to these ancillary procedures that we begin to encounter the surgeon's aide, be this a nurse, operating room technician or orderly. The induction and maintenance of anaesthesia by nurses is a commonplace example of the delegation of complex duties to one who is not a doctor. Pump technology in work on the heart is another example from a most sophisticated level of surgery. No one queries the employment of medical aides in such ways because they still come under the immediate direction of the surgeon or anaesthetist, with whom the

responsibility remains. We accept completely that a surgeon surrounds himself with the team he needs. Before we leave the particular for the general, however, we must remark how small a step it is to envisage technicians who have acquired such a range of skills as may justify, at least in their opinion, the delegation of independent responsibility.

To turn now to the general problem of delegation of responsibility, what exactly are we examining? I believe it is the ethical considerations which might underlie surgeons in general delegating the practice of surgery to others who have not gone the full course of surgical training, or conniving at such practice. One's immediate reaction is that there is nothing to discuss. Such delegation is unethical. To raise the matter at all reveals a lack of taste and more than a suspicion of treason.

We believe that surgery has been guided to its present high state by centuries of development of the professional characteristics of selection, training, examination and life-long supervision. We have evolved high standards of which we are intensely proud and we recognise how much we owe to the closed aspects of the profession. The inclusion of the 'worthy, expert and diligently examined' necessarily implies the exclusion of all the rest. If this exclusive element of a profession jibes with liberal views on restrictive practices, we would say that that is just too bad.

The drive behind the evolution of our profession is surely the conviction which every surgeon shares – that the patient demands the best we have to give, a best which must be at least above a certain level and which improves itself continually. A very large part of the work of this Federation in the past twenty years has been to encourage this proposition and to ensure high standards throughout the world. In our annual symposia we have explored many aspects, and in the past few years we have caught glimpses of a major difficulty which is relevant to my theme, namely that continuous improvement in surgical capability, especially in the last twenty-five years, has brought us near to, sometimes beyond, society's ability to use our gifts. I don't think we should digress into an examination of the material aspects of this limitation on surgical development. We have, or by now we should have, a fair idea of the minimum needs of surgery. Advance on this is more an argument in economics than an expression of ethical principles. We come up against these when we turn to consider the use of surgical manpower, especially in countries with a low health budget.

In the last few years crises of population growth and energy shortfall have exposed what A J P Taylor has called the great delusion of our age, a belief in limitless progress and the inevitability of limitless improvement. But we can still expect to provide the conventionally wealthy society with enough

surgeons to satisfy both the clinical needs and an ever lengthening training. There need be no gap in the delivery of surgical care to be filled by other means. So we insist unanimously, if with varying effectiveness, that the practice of surgery at all levels be limited to those who have completed a postgraduate surgical training, or are engaged under supervision in such training. I think we would agree that it is ethically undesirable to consider the delegation of surgical responsibility, that is to say independent responsibility to propose and complete curative operations, beyond these limits.

There is really no need for the individual surgeon in an affluent society to consider the matter further. But any body of surgeons which sets out to help the disadvantaged countries or to advise about surgery on a global scale must soon face up to the harsh reality which underlies the reformation of primary health care: that poor countries (and I think it is time we dropped these euphemisms for poverty on a national scale) cannot and will not, in future, be able to afford doctor/patient ratios which admit of conventional subdivisions of the profession.

We can be fairly sure that, whatever health economists propose, within the urban areas of these countries social pressures will sustain the position of the specialities as we understand it just now. To derive rules of conduct in the country beyond, we must have a clear idea of the locus of the surgeon and the range of his outreach. It is so difficult to suggest a universal definition because population density and geographical distances vary so widely from one country to another, but in our previous discussions we have accepted with reasoned optimism the equation of primary health care with various health workers, the health centre and the village; medical practice, doctors and the district hospital; specialist services at 'provincial hospitals'. This I believe to be a reasonable interpretation of the World Health Assembly's expectations for the rest of the millennium, and therefore a sound basis for further argument which might be along several different lines. I would suggest three:

The orthodox position

It is absolutely necessary that standards of surgical care do not fall from the levels we have worked so hard to achieve. Definitive surgery must remain the province of the fully trained surgeon. The responsibility for this should not be delegated. The efforts of the surgical community must be directed to ensuring an appropriate curriculum in general surgery, a judicious balance between generalists and specialists, an expanded surgical cadre at provincial hospitals, support for all improvements in transport and communications which will facilitate the transfer of patients to these centres.

An alternative view

The opposite pole, perhaps, in such an argument, is that the logistics of surgical care are so difficult that we must waive our scruples about delegating surgical responsibility and train subordinate groups to appropriate levels right down to the village. It is a case of *tout le monde à la bataille*. Surgery for all means surgery by everyone. It may suggest exciting extensions to the basic facilities of the health centre but, for the orthodox, it is the spectre of the barefoot doctor with a knife, anathema not only to the older surgical institutions but to the newly established surgeons of developing countries who have fought so hard to raise their status to international acceptability. A suspicion that any delegation of surgical responsibility is a step towards this sort of anarchy may well raise doubts in some minds about the propriety of our Federation involving itself in global health programmes.

A compromise

Common sense must surely guide us to a compromise between these views. We have an absolute duty to advance the standards of surgical care in respect not only of quality but also quantity. The latter may demand a build-up of the numbers of surgeons, but will require at least the devolution of some surgery to ordinary doctors – call them general practitioners, district medical officers or what you will. The propriety of such a delegation of responsibility must depend on the nature of the undergraduate curriculum and the emphasis therein on ‘obligatory operations’. Surgeons still have a collective responsibility for seeing that no one goes to the district hospital unprepared for this work, no

one is committed to it without the proper means, no one remains in it without proper supervision.

There are some with great experience in the field who will say that this simply does not go far enough. There is still a gap in surgical cover, one that can only be filled by training medical aides in simple surgical techniques, to carry out the actual operating under the general direction of a doctor. We have come back to the argument encountered earlier about anaesthetic technicians and the like. I remain unconvinced by the arguments for delegating responsibility at this level. It seems to me that the technically trained but medically unqualified person should continue to work only at the immediate direction of the doctor who retains full responsibility for his assistants’ actions. This does not preclude a need for regional or national training programmes for such assistants, and doubtless the immediacy of direction will vary considerably. Nonetheless, I believe we must make this important distinction between our attitude to surgery by our professional colleagues in small hospitals in poor countries and our attitude to technical assistants trained for specific procedures in such hospitals or for first aid in the health centres.

This is a distinction which it is easier to grasp for those in developing societies than for some of us in older institutions.

I have attempted this laboured analysis because I think we are unlikely to attack the surgical problems of poor countries squarely unless we agree the extent to which our rules of conduct must change under the conditions which obtain there. We must agree that what we are doing does not, in however good a cause, degrade something we have created. If we can rid ourselves of this fear, we shall be free to extend the range of surgical care to the limits of need.